

# TAMWORTH MEALS-ON-WHEELS

coordinated by **Tamworth Community Nurse Association**  
323-8511

## Thank you for Joining our Volunteer Team!

The following information is being provided as an **overview** in an effort to better acquaint you with our policies regarding the delivery of Meals on Wheels. Training with our seasoned driver(s) will provide additional details.

### Meal Pick up Schedule:

- 10:45am to 11:00am

**Delivery Schedule:** Our clients look forward to our daily visits and chats

- Monday – Friday
- 11 AM to 1 PM

### Meals:

Ossipee Concerned Citizens (OCC) in Center Ossipee prepare our meals.

- **Meal Pick up:** 3 Dore Street, Center Ossipee
- Meals will be packed in coolers and ready for pick up by **10:45 AM**
- Conway Daily Sun – are generally available at OCC to be delivered to clients with meal.
- **BONUS:** Sometimes there is a box by the door that contain extra foods and breads, pick some up for the recipients – they really appreciate it.
- A check list for OCC will be taped to the top of a cooler with all clients' names. As you deliver check mark the corresponding name, confirming delivery **\*\*this list will be left inside the empty cooler at the end of the route when coolers are dropped off at the TCNA office back door.**
- TCNA has two routes – T1 and T2 – collect the coolers that correspond to your route.

### Types of Meals: Regular, Allergy, or Diabetic

- Diabetic clients receive a special “S” dessert, instead of a sweet dessert.
- The delivery list will indicate “S” (special dessert) and “R” for regular (non-diabetic dessert).
- OCC is working hard to accommodate clients with allergies to different foods. When a client has an allergy OCC will label the top of the container with their name so the client will receive the allergy free meal. **\*This will be identified on the OCC list.**

### TUESDAYS

#### Quart of Milk

- Lo Fat or Whole
  - 1 milk per client
- \*\*some do not take milk**

List designation:  
See OCC list

**\*\* some do not take milk**

### WEDNESDAYS

#### Weekend Meals

- Frozen or Bag
  - 2 frozen meals  
or 1 bag per client
- \*\*some do not take weekend meals**

OCC List designation:  
'W' = Frozen  
'B' = Bag

**\*\* some do not take Weekend meals**

### VARIABLES

#### Weather & Holiday dependent

- Holiday Meals
  - Milk
  - Weekend
  - Blizzard Bags
  - Breakfast Bag
- \*\*may alternate delivery days**

**Procedure:**

- Knock on the door
- Announce yourself “Hello, this (your name) “Meals on Wheels”.”
  - The MOW program requires us to **See or Hear** the recipient.
  - Hand meal to client.

**CONCERNS:**

- Report to your TCNA Meals on Wheels Coordinator (323-8511) anything that concerns you about the meals delivery or the persons receiving the meals.

**END OF DELIVERY**

- Return empty coolers and insert OCC’s completed route check list (with notes) to the back of TCNA office.
  - 84 R Main Road, Tamworth
  - Insert OCC check list into one of the coolers.
  - **Cooler returns to OCC** \*details will be on drivers calendar.

**WEEKLY UPDATE EMAIL FROM TCNA:**

- Weekly updates are emailed to you containing:
  - Route 1 & Route 2 Schedules
  - Driver Calendar(s)

**\*\*\*THANKS SO MUCH FOR VOLUNTEERING YOUR TIME\*\*\***

**TAMWORTH MEALS-ON-WHEELS**  
*Coordinated by*  
**Tamworth Community Nurse Association**  
PO Box 352 Tamworth, NH 03886  
**323-8511**

Hello,

Because of our wonderful volunteers, over 10,000 Meals On Wheels meals were delivered to Tamworth residents in 2008.

**Thank you for all that you do to enrich the lives  
of those we serve!!**

In order to update our volunteer database, please supply the information requested:

Name: \_\_\_\_\_

Phone# \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Day(s) of the week that you may be available (please circle):

Monday

Tuesday

Wednesday

Thursday

Friday

Emergency contact person and phone # \_\_\_\_\_

*Thank you for the assistance.*

### BEAS STATE REGISTRY CONSENT FORM

(RSA 161-F: 49\*)

#### Employer Information

I hereby authorize the release of any adult abuse, neglect, and/or exploitation record that you might find concerning me to: ***(This portion must be filled out in order to be processed.)***

Employer name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

**For Official Use Only  
NH DHHS BEAS STATE REGISTRY  
NAME CHECK - CONFIDENTIAL**

No Finding  
Positive Finding  
Unable to Process - Correct and Resubmit  
Information Illegible  
Inaccurate Date of Birth (DOB) or  
DOB Missing  
Altered Form, Not Witnessed, or  
Too Dark  
Minor  
Other:

By: Angele Rivers  
Karen Conlon

Date: \_\_\_\_\_

#### Employee Information

#### PLEASE PRINT IN CLEAR BLOCK LETTERS

(If content is illegible, it will be stamped "Unable to Process" and returned.)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone \_\_\_\_\_ Gender:  Female  Male

*Also known by the following names (Maiden name, etc.):*

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Social Security #: \_\_\_\_\_

(Required)

(Optional)

Position: \_\_\_\_\_ Select one:  Applying  Current Position

Employee  Consultant  Volunteer  Other: \_\_\_\_\_

I understand that the information disclosed and provided by BEAS, under this State Registry Consent Form, is intended for use by the above-named employer in conjunction with my employment/volunteering.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required)

Fax to: (603) 271-6875 or Mail to: BEAS State Registry, 129 Pleasant Street, Concord, NH 03301

For more information, Visit: <https://www.dhhs.nh.gov/dcbcs/beas/registry.htm>,

Call: (603) 271-8154 or Email: [BEASStateRegistry@dhhs.nh.gov](mailto:BEASStateRegistry@dhhs.nh.gov)

OSSIPEE CONCERNED CITIZENS, INC.  
VOLUNTEER APPLICATION  
Must be 18 yrs or older to apply

Attach photo  
Here

Date \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Town \_\_\_\_\_  
Mailing \_\_\_\_\_ zip \_\_\_\_\_  
Home phone \_\_\_\_\_ work phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Date of birth \_\_\_\_\_  
Sex M \_\_\_ F \_\_\_ Marital status \_\_\_\_\_  
Please list current or past volunteer experience \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

references \_\_\_\_\_  
\_\_\_\_\_

How long have you lived in the Ossipee area? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Qualifications and Responsibilities required of a volunteer.

1. Be of reputable character
2. Have valid NH drivers license(meals deliverers ,DayCare drivers)
3. Be punctual
4. Be non-judgmental, allow clients to maintain dignity.
5. Report any emergency to 911 immediately.
6. Maintain neat and clean appearance.
7. Report any unusual behavior to OCC staff.

Background Checks

By signing below I authorize OCC to obtain information ,written ,oral and or other from any  
Law enforcement agency.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth. \_\_\_\_\_  
Drivers License # \_\_\_\_\_ Previous address \_\_\_\_\_

for office use only

approved by: \_\_\_\_\_ Date: \_\_\_\_\_

reviewed by: \_\_\_\_\_

comments; \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_